

NJDOH HANTAVIRUS INVESTIGATION WORKSHEET

CDRSS #: _____

DEMOGRAPHICS

Race <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander		Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
Occupation:		Pregnancy status <input type="checkbox"/> Pregnant <input type="checkbox"/> Not Pregnant <input type="checkbox"/> N/A

CLINICAL INFORMATION

Indicate Disease Suspected <input type="checkbox"/> Hantavirus pulmonary syndrome <input type="checkbox"/> Hantavirus infection, non-Hantavirus pulmonary syndrome	Onset Date ____ / ____ / ____
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Select a response for each sign or symptom below and include onset/resolution dates

Sign/Symptom	Response	Onset Date	Resolution Date
Abdominal discomfort	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	____ / ____ / ____	____ / ____ / ____
Acute Respiratory Distress Syndrome (ARDS)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	____ / ____ / ____	____ / ____ / ____
Chills	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	____ / ____ / ____	____ / ____ / ____
Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	____ / ____ / ____	____ / ____ / ____
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	____ / ____ / ____	____ / ____ / ____
Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	____ / ____ / ____	____ / ____ / ____
Elevated creatinine	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	____ / ____ / ____	____ / ____ / ____
Elevated hematocrit	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	____ / ____ / ____	____ / ____ / ____
Fever, Tmax _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	____ / ____ / ____	____ / ____ / ____
Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	____ / ____ / ____	____ / ____ / ____
Myalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	____ / ____ / ____	____ / ____ / ____
Nausea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	____ / ____ / ____	____ / ____ / ____
Neutrophilic leukocytosis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	____ / ____ / ____	____ / ____ / ____
Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	____ / ____ / ____	____ / ____ / ____
Thrombocytopenia (<150,000)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	____ / ____ / ____	____ / ____ / ____
Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	____ / ____ / ____	____ / ____ / ____
Other:		____ / ____ / ____	____ / ____ / ____

Was an underlying immunosuppressive condition present: <input type="checkbox"/> Yes, specify condition(s) _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	Was patient hospitalized because of this illness? <input type="checkbox"/> Yes, specify location and date(s) Hospital name: _____ Admission: ____ / ____ / ____ Discharge: ____ / ____ / ____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	Did patient seek care before hospital admission? If so, describe outcome (sent home, diagnosed as flu, etc.) <input type="checkbox"/> Yes, specify location and date(s) Provider name: _____ Phone number: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown
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CXR with unexplained bilateral interstitial infiltrated or suggestive of ARDS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Radiographic evidence of noncardiogenic pulmonary edema? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Was supplemental oxygen required? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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Was patient intubated? <input type="checkbox"/> Yes Date _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	Was patient on ECMO? <input type="checkbox"/> Yes Date _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	Did the patient die because of this illness? <input type="checkbox"/> Yes Date ____ / ____ / ____ <input type="checkbox"/> No	Was an autopsy performed? <input type="checkbox"/> Yes Autopsy findings: Cause of death: <input type="checkbox"/> No <input type="checkbox"/> Unknown
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RISK FACTORS

In the 8 weeks prior to illness onset, did the patient travel?

Location	Activities/ Possible rodent exposure	Dates
1.		___/___/___ - ___/___/___
2.		___/___/___ - ___/___/___
3.		___/___/___ - ___/___/___
4.		___/___/___ - ___/___/___

In the 8 weeks prior to illness onset, was the patient exposed to rodents or rodent excreta?

☐ Yes Date(s): ___/___/___
 ___/___/___

Describe exposure:

☐ No
☐ Unknown

Rodent exposure location (address)

Type of exposure:

- ☐ Cleaning
- ☐ Working
- ☐ Recreational activity (camping, hiking)
- ☐ Other, *describe*

LABORATORY DATA

Name of test/ Methodology	Name of laboratory	Specimen type	Specimen collection date	Result	Reference range
Hantavirus Antibody IgM / ELISA					
Hantavirus Antibody IgG/ ELISA					
PCR					
Culture/Viral Isolation					
Other:					
Other:					

ADDITIONAL CASE NOTES